Second, concerning surgical approach, they recommend a median sternotomy. We have used sternotomies in two cases of resected leiomyosarcoma originating in the left atrial walls close to the mitral anuli. In the reported case, the intra-atrial portion of the tumor was extremely large and filled most of the left atrium and the left lower pulmonary vein. Compared with our previous experiences, it seemed difficult to excise the tumor, the left atrial wall, and the left lung en bloc through a median sternotomy. Moreover, according to preoperative findings of computed tomography, magnetic resonance imaging, cineangiography, and echocardiography, the tumor appeared to be attached to only the left wall of the atrium around the orifice of the lower pulmonary vein. Therefore we chose the left thoracotomy approach. If the tumor had been on the right side of the left atrium, we would have chosen a median sternotomy as in the previous report.[1] Visualization of the remaining portion of the left atrial wall after resection of the tumor was good and the repair of the left atrium was very easy. Although it is not clear whether Babatasi and colleagues recommend a median sternotomy referring to their own experiences using both approaches, the surgical approach for this kind of lesion should be flexible, based on the preoperative findings of location and extension of the tumor.

Finally, efficacy of chemotherapy and/or radiation after surgery is still controversial for primary sarcoma of lung.[2-4] Although multimodality treatments are used with some success in advanced tumors, insufficient numbers of cases have been reported to confirm the benefit of adjuvant therapy after radical resection. At this moment, the two patients from our report are well and have no evidence of recurrence 30 months and 20 months after the operations, respectively.

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12/8/91859

The addition of saphenous vein graft to the left anterior descending artery in left internal thoracic artery hypoperfusion syndrome

To the Editor:

We read with interest the article on the surgical management of the left internal thoracic artery (LITA) hypoperfusion syndrome by Zünd and colleagues, published in the September 1997 issue of *The Journal of Thoracic Cardiovascular Surgery*.[1] We agree that the addition of a saphenous vein graft (SVG) to the hypoperfused left anterior descending (LAD) artery territory despite LITA graft implantation is beneficial to the patient, especially in the acute phase. Although there was no mortality from the ITA hypoperfusion syndrome in this series, it is a serious condition that is potentially lethal,[2,3] and reoperation is associated with increased morbidity.[4] In our practice, the addition of an SVG to a hypoperfused LAD is performed during the original period of cardioplegic arrest (along with the other elective grafts) and before clinical signs of ITA hypoperfusion syndrome occur. We implant an additional SVG to the LAD when the LITA is small and the flow is adequate but suboptimal. We are very pleased to note that the long-term flow rate of the LITA and SVG are satisfactory and there are no negative effects of one graft on the other, because we have not been able to carry out these measurements in our unit. The distance between the ITA graft and the suppplemental SVG was not discussed in this article, but recently it was shown that an increase in this distance improves the LITA graft survival.[5] We believe that our approach of prophylactically adding an SVG to a potentially hypoperfused LAD territory is less traumatic to the patient and to the surgical team.

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and supplemental vein graft anastomoses relevant in graft survival? Eur J Cardiothorac Surg 1998;13:36-41.

12/8/91858

Reply to the Editor:

The left internal thoracic artery (LITA) has become the conduit of choice for myocardial revascularization, because it has been proved that early mortality and morbidity are low.[1-3] At our institution 98% of all surgical revascularizations of the myocardium are performed with an LITA on the left anterior descending artery (LAD). Perioperative or early postoperative malperfusion of the LITA is a rare complication of coronary artery bypass grafting and may lead to the potentially fatal LITA hypoperfusion syndrome, which is caused by an acute imbalance between myocardial demand and nutritional support through the LITA.[4-6] Since we changed the preparation technique of the LITA by using very-low electrocautery and dilatation of the LITA by intraluminal infusion of 1% papaverine solution, the incidence of LITA hypoperfusion syndrome has decreased significantly to 1% in 1997. Recently Pagni and associates[7] demonstrated on a dog model that the increased distance (3-4 cm) of the additional vein graft implantation to the LITA might be an important factor in maintaining ITA patency. The additional vein graft implantation described in our article was at least 3 cm distal to the LITA implantation performed.

Still, and as we do agree with Galea and associates, the additional vein graft to the LAD is the therapy of choice for LITA hypoperfusion syndrome.

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12/8/91857

Use of Ultracision harmonic scalpel for isolation of intramyocardial coronary vessels during coronary revascularization of the beating heart

To the Editor:

Intramyocardial segments of coronary arteries are not only larger than other segments but also are frequently free of disease. For this reason and lack of any other suitable location, sometimes it becomes necessary to isolate this segment of the vessel. This is a relatively simple matter in an arrested and flaccid heart. However, it becomes a formidable surgical challenge in operations on the beating heart for the following reasons.

The dissection of intramyocardial arteries from surrounding fat and muscle fibers requires a small and bloodless field to identify, at times, vessels as small as 1 mm. During beating-heart coronary revascularization with a small moving target and the vessel obscured by surrounding fat and muscle fibers, a bloodless field, although attainable, is hardly achieved by

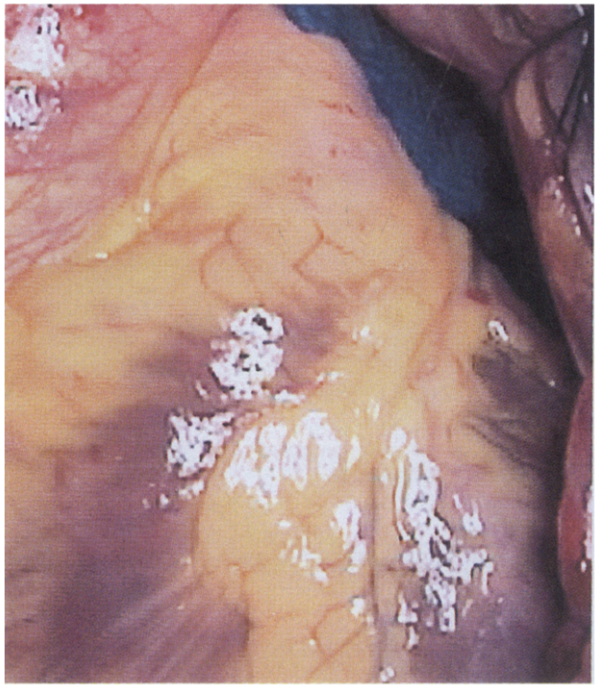

Fig 1. Intramyocardial left anterior descending coronary artery before division of myocardial fibers.